

General Information for Authorization

Services Authorised	Taboli			*****				1	
Org 1.	511					Servi	се Туре	2. MISC	
	·				Client la	nformat	tion	,	
Name		3. CLIENT	NAMI	C		Clien	t ID	4. 123456789WA	
Living Arra	ngements	5. N/A				Refe	rence Auth #	6.	
					Provider	Inform	ation		
Requesting	g NPI#	7. 11234567	189			Requ	resting Fax #	8. XXXXXXXXXX	
Servicing i	NPI#	9. 11234567	89			Nam	e	10. SERVICING PROV NAME; LABORATOR	
Referring i	VPI #	11. 1123456	789			Refe	rring Fax #	12. XXXXXXXXXX	
Service Sta		13.						14. N/A	
				Se	rvice Requ	est Inf	ormation	. 1	
15. Geneti		ing requested	i:			16. N	V/A	17. N/A	
	NEA# N/A	T		–		19. N	I/A	A. D. J. J.	00 T
20. Code Qualifier	21. National Code	22. Mod		Inits/Days equested	24. \$ Am Reques	iount ited		25. Part # (DME Only)	26. Tooth or Quad #
C	СРТ			#	N/A	١.,		N/A	N/A
		,							
								•	
			J.		Medical	Informa	ation		
Diagnosis	Code	27. IC	CD-9	Diagnosi	s name	28. I	DIAGNOSIS NA	ME	
Place of se	ervice	29. 11	[
30. Comm	ents:	•							

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The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. <u>HIPAA Compliance</u>: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME	ACTIO	N ELDS MUST BE TYPED.		
	Org required	Enter th	e Number that Matches the Progra	m/Unit fo	r the Request
		500 - D 501 - D 502 - D 509 - E 504 - H 505 - H 506 - In 507 - Ju 508 - M 510 - M 511 - O 513 - P 514 - A 515 - Ti	ivision of Alcohol and Substance A ental urable Medical Equipment (DME) conomic Services Administration (B ome Health ospice patient Hospital uvenile Rehabilitation Administratio	buse (DA: ESA) (DSI: n (JRA) (I PM & R)	SA) HS) DSHS)
	Service Type required	Enter th	e letter(s) in all CAPS that represe	nt the ser	vice type you are requesting.
2		BB BEM BGS BP BS C CIERP CSC CWN DASA DEN ESA FSFS HB HEA HH HSPC ITA JRAC	Bath Bench Bath Equipment (misc) Blood Glucose Monitors Bone Growth Stimulator Breast Pumps Bariatric surgery Bariatric surgery stage 2 Commode Cochlear Implants Cochlear Implant Ext Repl Prts Commode/Shower Chair Crowns DASA Dentures Enteral Nutrition ESA Floor Sitter/Feeder Seat Hospital Beds Hearing Aids Home Health Hospice Infusion/Parental Therapy Inpatient admission - ITA JRA	PHY PL PMR PROS PRS PSY PTL PWNF PWNF PHYS R RBS RE RLNS RM S SBS SC SCAN	Orthotics PAS Duty Nursing Pharmacy Patient Lifts PM and R Prosthetics Prone Standers Psychotherapy Partial Power Wheelchair - Home Power Wheelchair - NF Power Wheelchair - NF Physician Services Respiratory Rebases Room equipment Relines Readmission Surgery Specialty Beds/Surfaces Shower chairs MRI/PET Scans Standing Frames
		LTAC MC MISC MN MWH MWNF O ODC ODME OOS OP.	LTAC Medication Miscellaneous Medical Nutrition Manual Wheelchair - Home Manual Wheelchair - NF Other Orthodontic Other DME Out of State Ostomy Products	SF SGD SSIP T TRN TU US V VNSS VOL WDCS	Standing Frames Speech Generating Device Short Stay (In-Patient) Therapies (PT/OT/ST) Transportation TENS Units Urinary Supplies Vision Vagus nerve stimulator surgery Inpatient admission-Voluntary Wound/decubiti care supplies

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
4	Client ID: Required.	 Enter the client ID = 9 numbers followed by WA. For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the client ID.
5	Living Arrangements	The PA will be updated and you will be able to bill the services approved. Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

Field	Name	Action	
		ALL FIELDS MUST	BE TYPED
	Org required		t Matches the Program/Unit for the Request
**************************************		500 - Division of Alection 501 - Dental	ohol and Substance Abuse (DASA)
		502 - Durable Medica	1 Fauinment (DMF)
			ces Administration (ESA) (DSHS)
		504 Home Health	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
		505 Hospice	
		506 - Inpatient Hospit	al
4			litation Administration (JRA) (DSHS)
1		508 - Medical	
		509 Medical Nutri	tion
	·/	510 - Mental Health	
		511 - Outpt Pro	
			ne & Rehabilitation (PM & R)
		~ ~	bility Services Administration (ADSA)
		515 Transportation 516 Miscellaneous	
		310 IVIISCENAMEOUS	
	Service Type required	Enter the letter(s) in a	Il CAPS that represent the service type you are
	Bervice Type required	requesting.	if CAI o mai represent the solvice type you are
		requesting.	
		AA Ambule	ntory Aids
		BB Bath Bo	▼
-			quipment (misc)
			Glucose Monitors
		BGS Bone G	rowth Stimulator
		BP Breast l	Pumps
		BS Bariatri	i c surgery
		BSS2 Bariatri	c surgery stage 2
		C Commo	•
			ar-Implants
			ar Implant Ext Repl Prts
2			ode/Shower-Chair
		CWN Crowns	•
		DASA DASA	'
		DEN Denture	· · · · · · · · · · · · · · · · · · ·
İ			Nutrition
		ESA ESA	
		'	itter/Feeder-Seat
1		HB Hospita	
		HEA Hearing	
		HH Home I	· ·
		HSPC Hospic	
			n/Parental Therapy
			nt admission—ITA
		JRA JRA	
<u> </u>		LTAG LTAG	

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Field	Name	Action	
		MC	Medication
	T T T T T T T T T T T T T T T T T T T	MISC	Miscellaneous
		MN	Medical Nutrition
		MWH	Manual Wheelchair - Home
		MWNF	Manual Wheelchair NF
		O	Other
		ODG	Orthodontic
		ODME	Other DME
	1	OOS	Out of State
		OP	Ostomy Products
		OS	Orthopedic Shoes
		OTC	Orthotics
		PAS	PAS
		PDN	Private Duty Nursing
		PHY	Pharmacy
		PL	Patient Lifts
		PMR	PM and R
		PROS	Prosthetics
		PRS	Prone Standers
		PSY	Psychotherapy
		PTL	Partial
		PWH	Power Wheelchair Home
		PWNF	Power Wheelchair - NF
		PWNF	Power Wheelchair - NF
	1 1	PHYS	
		1	Physician Services
		R	Respiratory
		RBS	Rebases
		RE	Room equipment
		RLNS	Relines
		RM	Readmission
	•	\$	Surgery
		SBS	Specialty Beds/Surfaces
		SC	Shower chairs
		SCAN	MRI/PET Seans
		SF	Standing Frames
		SGD	Speech Generating Device
		SSIP	Short Stay (In-Patient)
		Ŧ	Therapies (PT/OT/ST)
		TRN	Transportation
		TU	TENS Units
-		US	Urinary Supplies
		¥	Vision
		VNSS	Vagus nerve stimulator surgery
		AOF	Inpatient admission-Voluntary
		WDCS	Wound/decubiti care supplies
3	Name: Required.		st name, first name, and middle initial of the patient you
<u>.</u>		are requesti	ng authorization for.
	Client ID: Required.	T	ient ID = 9 numbers followed by WA.

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5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc. NOT REQUIRED FOR GENETIC TESTING
6	Reference Auth #:	If requesting a change or extension to an existing authorization, please indicate the number in this field.
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21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier:	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for
24	\$ Amount Requested: Required. N/A	the appropriate unit/day designation for the service code entered). NOT REQUIRED FOR GENETIC TESTING Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee

25 Part # (DME only): Required for all "By Report" codes requested. Tooth or Quad#: Required for dental requests Tooth or Quad#: Required for dental requested. NOT REQUIRED FOR GENETIC TESTING Enter the tooth or quad number as listed below: QUAD 00 full mouth 01 upper arch 10 upper right quadrant 20 upper left quadrant	
Part # (DME only): Required for all "By Report" codes requested. Tooth or Quad#: Required for dental requests NOT REQUIRED FOR GENETIC TESTING Enter the tooth or quad number as listed below: QUAD On full mouth O1 upper arch O2 lower arch O2 lower arch O3 upper right quadrant	Э
all "By Report" codes requested. Tooth or Quad#: Required for dental requests Tooth or Quad#: Required for dental requests DOT REQUIRED FOR GENETIC TESTING Enter the tooth or quad number as listed below: QUAD On full mouth	Э
Tooth or Quad#: Required for dental requests Tooth or Quad#: Required for dental requests NOT REQUIRED FOR GENETIC TESTING	
dental requests Enter the tooth or quad number as listed below: QUAD 00 full mouth 01 upper arch 02 lower arch 10 upper right quadrant	
QUAD 00 full mouth 01 upper arch 02 lower arch 10 upper right quadrant	
26 On full mouth O1 upper arch O2 lower arch O2 upper right quadrant O2 upper right quadrant O2 upper right quadrant O3 upper right quadrant O4 upper right quadrant O5 upper right quadrant O5 upper right quadrant O6 upper right quadrant O7 upper right q	
26 01 upper arch 02 lower arch 10 upper right quadrant	
26 02 lower arch 10 upper right quadrant	
10 upper right quadrant	
10 upper right quadrant	
20—upper left quadrant	
30—lower left quadrant	
40—lower right quadrant	
Tooth # 1-36, A-T, AS-TS, 51-82 and SN	
27 Diagnosis Code: Enter appropriate diagnosis code for condition.	
28 Diagnosis name Short description of the diagnosis.	
Place of Service Enter the appropriate two digit place of service code.	
Use 11 (office) or 81 (INDEPENDENT I	AB)
30 Comments: Enter any free form information you deem necessary.	